



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HOUSTON MEDICAL GROUP

MFDR Tracking Number

M4-17-2813-01

MFDR Date Received

May 22, 2017

Respondent Name

METROPOLITAN TRANSIT AUTHORITY

Carrier's Austin Representative

Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...as of today we have yet to receive either a payment or denial. I have enclosed the original bills as previously submitted as well as the medical documentation and proof of timely filing."

Amount in Dispute: \$1,771.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The attached STARR analysis letter dated 6/6/17 provides a detailed explanation of the fee reduction."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 2, 2016 through June 15, 2016	98940, 97110, 97140 and 97035	\$1,771.77	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment denied/reduced for absence of precertification/authorization
 - 197 – 30 days from the date of issue 05/12/16 is 06/11/16; therefore, preauthorization is required to complete PT sessions beyond 30 days
 - 197 – Per ODG preface: Physical Therapy Guidelines (7) Generally there should be no more than 3 or 4 modalities/procedural units in total per visit, allowing the PT visit to focus on those treatments where there is evidence of functional improvement, and limiting the total length of each PT visit to 45-60 minutes (an average of 3 or 4 modalities/procedural units per visit) unless additional circumstances exist requiring extended length of treatment. If additional circumstances are present, documentation must support exceeding the ODG PT Guidelines. The extended length of treatment exceeds the ODG Guidelines; therefore, preauthorization is required.

- 198 – Payment denied/reduced for exceeded precertification/authorization
- P12 – Workers’ compensation jurisdictional fee schedule adjustment
- 198 – Exceeds pre-authorization #13524, dated 5/12/16 which approved 10 PT sessions no more than 4 modalities/units per visit as agreed upon by Marissa

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Did the requestor obtain preauthorization for the disputed services rendered on June 15, 2016?
3. Did the insurance carrier issue payments for CPT Codes 97110, 97140 and 90735 rendered on June 2, 2016, June 8, 2016 and June 9, 2016?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 98940 rendered on June 2, 2016, June 8, 2016, June 9, 2016 and CPT Codes 98940, 97110 and 97140 rendered on June 15, 2016. The insurance carrier denied the disputed charges with denial reason code “198 – Exceeds pre-authorization #13524, dated 5/12/16 which approved 10 PT sessions no more than 4 modalities/units per visit as agreed upon by Marissa.” and “198 – Payment denied/reduced for exceeded precertification/authorization.”

28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, “(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care...”

28 Texas Administrative Code §134.600(p) (5) states in pertinent part, “(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning....”

The requestor submitted a preauthorization letter dated May 12, 2016 issued by Work Link a certified URA. The certification letter indicates that authorization was obtained for “Physical Rehabilitation x 10 visits, no more than 4 units per visit (modifications per Marissa with Dr. Pham via T/C 5-12-16). This review has been performed by and applies only to the specific services listed above. This notice expires 30 days from the date of issue. Any additional services will require a separate process.” The certification letter identifies the CPT Codes authorized as CPT Codes 97110, 97035, 97140, G0283 and 98940.”

Review of the submitted documentation support that the requestor obtained preauthorization for the disputed services, however exceeded the number of units (4 units per visit) per visit. The insurance carrier paid the following units per date of service:

Date of service June 2, 2016

CPT Code 97110 x 3 units – Paid by the insurance carrier

CPT Code 97035 x 1 unit – Paid by the insurance carrier

CPT Code 98940 x 1 unit – Denied by the insurance carrier for exceeding the 4 units– Denial reason code “198”

Date of service June 8, 2016

CPT Code 97110 x 3 units – Paid by the insurance carrier

CPT Code 97140 x 1 unit – Paid by the insurance carrier

CPT Code 98940 x 1 unit – Denied by the insurance carrier for exceeding the 4 units – Denial reason code “198”

Date of service June 9, 2016

CPT Code 97110 x 3 units – Paid by the insurance carrier

CPT Code 97140 x 1 unit – Paid by the insurance carrier

CPT Code 98940 x 1 unit – Denied by the insurance carrier for exceeding the 4 units– Denial reason code “198”

The Division finds that disputed CPT Code 98940 exceed the number of units pre-authorized by the insurance carrier, as a result, reimbursement cannot be recommended for CPT Code 98940 rendered on June 2, 2016, June 8, 2016 and June 9, 2016.

2. The requestor seeks reimbursement for CPT Codes 97110, 98940 and 97140 rendered on June 15, 2016. The insurance carrier denied the disputed services with denial reduction code "197 – Payment denied/reduced for absence of precertification/authorization" and "197 – 30 days from the date of issue 05/12/16 is 06/11/16; therefore, preauthorization is required to complete PT sessions beyond 30 days."

28 Texas Administrative Code §134.600 (p) (5) states in pertinent part, "(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning...."

28 Texas Administrative Code §134.600 states in pertinent part, "(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the... (3) number of specific health care treatments and the specific period of time requested to complete the treatments..."

Review of the submitted documentation does not support that the requestor obtained concurrent review to extend the 30-day expiration date of the obtained pre-authorization letter. The division therefore finds that the disputed services rendered on June 15, 2016 were not preauthorized as required pursuant to 28 Texas Administrative Code 134.600 (p)(5).

3. The requestor seeks reimbursement for CPT Codes 97110, 97140 and 97035 rendered on June 2, 2016, June 8, 2016 and June 9, 2016. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

The insurance carrier states, "...the charges for CPT codes 97110, 97140 and 97035 for dates of service (DOS) 6/2/16, 6/8/16 and 6/9/16 listed on the DWC060 have been paid at fee schedule. Please see Attachment 1, this attachment includes the missing EOBs for DOS 6/2/16, 6/8/16 and 6/9/16. The corresponding CMS-1500s are included as well. The check for these three DOS, check # (check #) dated 9/19/16, is enclosed in Attachment 2." The Division applied 28 Texas Administrative Code 134.203(c) (1 -2) to determine the MAR. The Division finds the following:

Procedure code 97110, service date June 2, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.006 is 0.44264. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.92029 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$52.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$52.29. The PE reduced rate is \$39.72 at 2 units is \$79.44. The total is \$131.73. The insurance carrier paid \$156.87, therefore no additional reimbursement is recommended.

Procedure code 97035, service date June 2, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.21 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.21399. The practice expense (PE) RVU of 0.14 multiplied by the PE GPCI of 1.006 is 0.14084. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.36438 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$20.70. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$16.70. The insurance carrier paid \$20.71, therefore no additional reimbursement is recommended.

Procedure code 97110, service date June 8, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.006 is 0.44264. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.92029 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$52.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$52.29. The PE reduced rate is \$39.72 at 2 units is \$79.44. The total is \$131.73. The insurance carrier paid \$156.87, therefore no additional reimbursement is recommended.

Procedure code 97140, service date June 8, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.43817. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.006 is 0.4024. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.85012 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$48.30. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$36.87. The insurance carrier paid \$48.31, therefore no additional reimbursement is recommended.

Procedure code 97110, service date June 9, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.006 is 0.44264. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.92029 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$52.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$52.29. The PE reduced rate is \$39.72 at 2 units is \$79.44. The total is \$131.73. The insurance carrier paid \$156.87, therefore no additional reimbursement is recommended.

Procedure code 97140, service date June 9, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.43817. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.006 is 0.4024. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.85012 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$48.30. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$36.87. The insurance carrier paid \$48.31, therefore no additional reimbursement is recommended.

4. The Division finds that the requestor is therefore not entitled to additional reimbursement for the disputed services. As a result, \$0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 29, 2017
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.